

ASIAN MEDICAL SYSTEMS: A SYMPOSIUM ON THE ROLE OF COMPARATIVE SOCIOLOGY IN IMPROVING HEALTH CARE*[1]

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PREFACE

HISTORIANS, sociologists, anthropologists, a philosopher and physicians trained in modern and Asian medicine came together at Burg Wartenstein, Austria, in July 1971 to discuss the pluralistic medical systems in Asian countries. We were concerned with the Great Traditions of Chinese, Hindu and Arabic medicine, particularly in relation to the emergence of "Western" or international scientific medicine in the nineteenth and twentieth centuries. Analyses of these traditions are theoretically important for medical sociology and relevant to the practical problems of improving medical care. The symposium here recorded was devoted to these problems.

Charles Leslie organized the symposium and has edited the transcript for publication. Carl Taylor, who led the symposium, has worked in many countries, but he grew up in India and has a lifetime interest and knowledge of that country.

OPENING COMMENTS BY CARL TAYLOR

A tourist was lost in the fog in London. As he went along, bumping into walls and falling over curbs, he kept calling out, "Where am I? Where am I going?" Finally, a voice came out of the fog and said, "You're going into the Thames; I'm just getting out". In comparative research on medical systems, we have been fumbling around individually in a fog. Now we should come together to create an essentially new interdisciplinary field.

The realities we must take into account in creating this interdisciplinary field may not be what some anthropologists assume them to be. Raymond Firth said to me something to the effect that if anthropologists are going to join in research on medical systems, they will have to get money from the vast resources devoted to health research. He added that because of the shortage of personnel, we have to train anthropologists specially to get them to move into this area. Several stereotypes were buried in that comment, especially the idea of vast resources in the health field. A further comment by Charles Leslie was that the best anthropological research will probably be done outside the health services, where the anthropologist can do what he likes to do: stand outside and study events in a relatively uncommitted manner. I have the impression that anthropologists who take this approach think they are writing beautiful and professionally satisfying studies, but then they wonder why nobody makes use of them. I admit that this may be an old-fashioned stereotype of anthropologists. We have got to learn that the stereotypes anthropologists have of doctors and that doctors have of anthropologists get in the way of good communication.

My question is, how can historical and anthropological inquiry on comparative systems

* This is an edited account of a conference organized by the author (Ed.).

of health care contribute in a practical manner to medical care in Asian countries? A related question is, how can comparative studies of medical systems contribute to the general theory of social change? Theoretical understanding is part of the justification for doing this type of work, and I will comment briefly on it [2].

In theoretical analyses of social change, especially in the shift to modernity, medicine may be a more important index than has been realized. In China and India, particularly, medicine emerged as a specific focus of cultural tension in the traditionalism/modernity dilemma. Furthermore, a person's view of his own future as part of his world view is influenced very strongly by his expectation of life, and by his expectation of illness. When these expectations change as a result of better health care there is a whole shift in orientation. This shift in world view may influence planning for children as more children begin to survive, and thus have a dramatic impact on the demography of the whole society.

A practical issue in planning comparative research on Asian medical systems is that whether or not studies of the relationships between traditional and modern medicine are utilized depends on general medical policy, and such policy is part of the political decision-making process. When we study the possibilities of using traditional medical systems in the government health services, we will only fool ourselves if we think we can have a determining influence. The more important considerations of which we should be aware are political issues, and we should work within them. This awareness has two interacting dimensions. One is symbolic. In this regard I like Ralph Croizier's statement about China, "...the name 'Chinese medicine' will probably be with us for some time. And so long as it is, so long as there is a concern that medicine in China will not be all 'Western medicine', ... non-medical factors ... are going to be relevant to the future of Chinese medicine—and to the future of medicine in China". This statement puts in clear perspective the fact that the symbolic aspect of having something distinctly Chinese (or Indian) is real and is going to determine whether the label is going to be used.

However, the second dimension is that within the framework of existing medical policies, our research can influence what is included under the label. I will pose three questions which will be the basis for the rest of my discussion. The first question is, "What should be included from traditional medicine in health services which are under governmental control?" The second is, "How can this be done?" And the third question is, "Who among the indigenous practitioners can be most readily involved in this integration of services?"

Let us turn to the "what" question. In the first place, we do not want to integrate into governmental health services anything that is dangerous. For example, in studies of the Dai, or indigenous midwife, our Johns Hopkins group in the Punjab is analyzing what they do under three headings: practices that are dangerous, those that are neutral according to our best present knowledge, and those that are positively beneficial. We need to analyze the practices of the whole range of traditional curers in this manner.

One slogan that is frequently heard in India and other Asian countries is that indigenous drugs are innocuous, that even if they do not benefit patients, they cannot harm them. Although we hear this repeatedly, I do not believe it. Many mistakes are being made because of the improper use of some of these drugs. For example, mercurials and other heavy metals that are extensively used in Ayurvedic and Islamic medicine are extremely dangerous. Yet because they are being used in traditional medicine some people suppose that they should be exempt from questioning.

Let me give another example. In Jamaica doctors found a number of deaths coming to autopsy, particularly in children and younger adults, in which there was a peculiar cirrhosis

resulting in tremendous liver damage. It was a challenging problem because it did not fit any of the known categories of liver disease. Finally someone with an anthropological bent suggested that maybe it was caused by the "bush tea" that was widely used as an indigenous medicine. The process by which medical research was then able to identify the toxic chemicals in "bush teas" responsible for this clinical syndrome is a fascinating story. We must be aware of the frequency of this sort of sequence in objectively studying traditional health practices and recognize that prolonged usage has little meaning in scientific verification unless controlled research has been done.

Of course, we must look for the beneficial effects of traditional practices. This is where much research has already been done. One hears frequently about Foxglove and Rawolfia. In addition, we must study the components of traditional medicine that provide pastoral care, the "comfort functions" of good medical care that are derived from culturally conditioned practices which support general health.

With respect to practices that seem neutral, there is a question I consider still open. I can argue on both sides of this question myself, and raise it because we need to recognize that there is a problem. One notion is that if you cannot find anything wrong with something that is being done and is culturally acceptable, you should leave it alone on the assumption that if it persists it must be all right. This represents a neutral stance toward an apparently neutral practice. An opposite position has recently been taken by the Food and Drug Administration in the United States, which very clearly now insists that if a medication does not help, it must be eliminated from approved usage.

Another area of research is based on the idea of integrating aspects of indigenous practice to improve communications between health professionals and patients. Possible examples are: (a) using local terminology for disease and therapy even though this may require including concepts and standards with no scientific validation, i.e., the hot-cold categories of food which have been extensively studied in Latin American folk medicine and are also used throughout Asia; (b) concepts of growth and development that directly influence health practices; (c) child rearing practices that influence life patterns, such as William Caudill's research comparing American and Japanese child care and its influence on general response to the social and physical environment. Such topics provide an exciting area of research that will have immediate applicability to improving health services.

Another type of research is to identify traditional practices and beliefs that act within the multiple causal complexes that are responsible for many chronic diseases. Fred Dunn uses the term, "behavioural epidemiology", for this type of research. A good example is the demonstration that smoking causes lung cancer, emphysema and other afflictions of the heart, stomach and other organs. In every society cultural patterns and social relationships influence the occurrence of different diseases. We have mentioned Jamaican "bush tea". Even more clearly derived from indigenous beliefs is the example mentioned by Gananath Obeyesekere, in which the loss of semen through urethritis, or its equivalent in women of vaginitis, is a "cultural disease" that causes more concern and worry in Ceylon and India than most other conditions. Yet another kind of investigation is the work of our Johns Hopkins team in the Punjab in which we have shown that magical practices associated with marasmus essentially negate usual approaches to care.

Now I turn to the "how" question of making anthropological research useful in improving medical care in Asian countries. The "how" issue is again primarily determined by political considerations. But as professional specialists, we may influence health planning. We return to the question of whether we can do the best research by working outside or within the

political structure of the modern medical system. For the best prospects of influencing decisions that will improve health services, I think you have got to work within the system. There are ways of working inside the system and still maintaining objectivity. But if you stay outside of the bureaucratic system of modern medicine, your research will not have much practical effect, and you will ask plaintively, "Why doesn't somebody use my wonderful findings".

A direct contribution to the channeling of resources would be to help Asian health planners and administrators control the massive pharmaceutical trade of improper and unqualified medical practice. This is an area which causes much frustration. Objective research in medical sociology and anthropology can provide practical insights and approaches.

The third question is "who" among the wide range of practitioners of Asian medicine can be used to improve governmental health services. First, let us consider the elite urban specialists in private practice of Ayurvedic or Chinese medicine. They will continue to fill an important role in Asian countries. I do not think we need to worry too much about the future of these specialists because in an entrepreneurial manner they are taking care of themselves. They set the standards for the practice of the traditional systems of medicine. They are in lucrative urban practices, and I think they are going to continue to be there. We recognize them; we learn from them; we work with them in research on traditional drugs; but having said that I think we must move on to other groups among whom social research may have more influence in improving state health services.

Next come the village practitioners. Here we have a massive range of categories, from regular indigenous faith healers and many types of one-disease specialists and those who use only one category of drugs or treatments on various diseases. Many among this broad range of village practitioners are going to be rendered non-functional and replaced gradually as organized health services spread. This will be a spontaneous process. In Turkey Attaturk tried to legislate against these village practitioners, but this was a classic example of a law which did not work because there was no one to replace them, and new categories of practitioners called "needle-men" emerged. We can encourage administrative decision-makers in health services not to make the same mistake because such laws cannot be enforced and they cause resentment. It is more effective to rely on a spontaneous process of replacement in which people become dissatisfied with traditional practices when they learn about and have access to something better.

It does seem practical, however, to define those categories of traditional village practitioners who can be trained for particular roles in the health services. I consider this to be an exciting area for research. The best example is the indigenous midwife, called a Dai in India. Here is an area in which most governments want help. Contributions can have immediate practical value, and good research may build relationships with Asian policy-makers and facilitate other applied research.

Another issue relevant to the "who" question arises in connection with efforts to develop educational programs for traditional village practitioners. In India and some other countries, support exists for schools where the urban elite practitioner can be trained. But these schools have not been effective in devising educational programs to give special training to meet village needs. The Maoist approach to training "barefoot doctors" should be contrasted with the democratic and spontaneous evolutionary approach India has used for training the ANM, auxiliary-nurse-midwife, as the key peripheral worker in the health center team. The contrast has tremendous educational implications because of the lack of compulsion available in the political system and the need to provide inducements.

I want to conclude by listing some constraints and some favorable factors which determine the effectiveness of applied research of the kind I have been discussing. The biggest constraint is the attitude of the medical profession. I say this frankly and humbly. We have to consider both organizational blocks and individual attitudes. It is necessary to realize that part of the problem is the basic insecurity of the medical profession in many Asian countries. For example, Indian doctors have acquired from Western countries an image of a society in which medical professionals have high prestige. This status applies mainly to private practitioners with an affluent practice. But most find themselves working in a socialized system of health care much closer to the Soviet model. They are very sensitive about the fact that they end up as a low status group in the general organization of the government. It is true that ministries of health rank very low in political and economic status in the governments of many developing countries. This creates insecurity, and health policy decision-makers tend to be defensive and easily threatened by anything which might further lower their prestige. It is important to realize that no social research will be acceptable unless these administrators can be convinced that it will help their work. Government agencies often work primarily as a blocking mechanism, and in these bureaucratic relations issues of status and future prospects are obviously important.

A second constraint is the lack of cooperation between the national, regional and local levels of organization. A third is the difficulty that health specialists with different kinds of training have in communicating with each other. This is particularly true of those who are trained in systems as different in their basic concepts as the Asian medical traditions and modern medicine. A fourth is a problem of conceptualization, for as yet we do not have sophisticated analytic models which will help us understand the pluralistic medical systems of Asian countries. We all too often lump divergent practitioners together as though they were all the same.

Now let me list some favorable factors. In India particularly, and it is also obviously true for China, there is a political commitment to maintain at least a symbolic role for traditional medicine in the governmentally supported system of health services. This means that research on the history and social organization of traditional medicine in its relationship with modern medical institutions will be considered relevant by policy-makers.

A second favorable circumstance is that leaders within the medical profession have learned that planning for health services will not be easily accomplished. They are looking for help because standard approaches have failed. Third is the fact that almost all developing countries have accepted the social responsibility of providing health services reaching out to rural areas. This provides a rationale for research on how this process can be accelerated. Development of mass services for rural areas may come faster than once seemed possible. I would not have believed 15 years ago when India started the present massive expansion of rural health centers that they would have been able to now have about 5000 health centers, or almost one in every community development block in the country.

Finally, a consideration that applies most directly to India is the strong official commitment to family planning. Government health workers recognize their need for help in this work. They are aware of and eager for research on the cultural and Ayurvedic roots of popular thinking about health, procreation and family structure in the hope that it will facilitate the effective implementation of the national family planning program.

DISCUSSION

William Caudill. Your work has been in India largely, and I suppose you have been asked

by the government to come in and be helpful. I have the perspective of someone who works in Japan. What gets in the way of my thinking about how to make my work practical, in the framework of practicality you assume, is that I cannot conceive of the Japanese government asking me to help them with their problems of health planning. Japan is perfectly competent to take care of its own problems.

I also think of my own country. Like many other Americans, in recent years I have had some qualms about what I might be doing that would make more sense than what I am doing. In my own area of speciality the United States government has committed itself to community mental health centers, with one center for every several 100,000 people. About 40 per cent of this goal has been achieved, and the program is going ahead. Yet, I feel that the medical profession does not know how to run these centers. The whole idea of a community health center requires research on the demographic, social, interpersonal and cultural characteristics of the society in that (horrible term) "catchment area". A "catchment area" could have a meaningful definition, but often it does not. When I look at medicine in the United States, it needs exactly the same practical research and point of view that you say needs to be applied in the Indian situation.

Japan also needs research to bring the worthy attributes of Chinese medicine into better relationship with other medical practices. They certainly have deficiencies in their medical program, although I do not think Westerners have any immediate role to play other than the collaborative and collegial one that presently exists. For practical and for theoretical understanding we can learn from each other by working comparatively.

I am just saying that my focus is a little wider than yours. You are talking about a developing country situation.

Carl Taylor. The research my department at Johns Hopkins has conducted in India did not occur just because the Indian government asked us to come in. Our discussions with the Indian government led to mutual recognition of shared interests. Our initiatives coincided with their need. Our first project on rural orientation of physicians moved into three research projects on population, nutrition and functional analysis of rural health services. New activities have evolved from long-term research relationships. We went to a great deal of trouble to build practical programs related to the ministry services and try to respond to their initiatives on specific subjects.

One of the reasons research projects in India have been criticized for academic colonialism is the strong feeling that foreign research workers take data off and Indians have no control on the interpretations given to the data. This is perhaps their greatest worry. If we tie our work into ministry interests, we can have a continuing evolution of research with pragmatic results.

Charles Leslie. Consensus to do research on what aspects of indigenous Asian medicine could be integrated into the state health services should not be difficult. The issues will sift down to empirical questions, and I believe that traditional practitioners are open to innovation and new ideas. This should be even more the case if they feel they are participating in new programs that respect their ideas.

Among the harmful items in traditional practice I can add another example to your list: glaucoma caused by a poppy that got into indigenous medicine in India and Pakistan when it was erroneously identified with a plant mentioned in Ayurvedic texts. This poppy originally came from Mexico, and was introduced to India by the Portuguese in the sixteenth or seventeenth centuries. Knowledge generated by research which demonstrates dangers like the use of this poppy should spread and be accepted. The medicines have been studied, though more work needs to be done.

Research about *how* the traditional medicine can be used, and *who* to incorporate into the health services has been almost completely neglected and is crucial for improving the delivery of medical care. I question whether this research is always most effective when it is done by scholars within the medical bureaucracy. Work done within the system must deal with constraints that are different from work done outside the system. An example of one advantage someone outside the system can have comes from the remark a highly placed medical educator made to me, "I am glad an American has taken up the study of indigenous medicine because you can expose a lot of the error and superstition that we must tolerate". Naturally, he would expect me to expose people that he disagreed with. But the point is well taken that it is good to have an outsider study a system of health practices without the constraints of researchers who work inside the system.

When you ask which traditional practitioners should be studied to see how they might take new roles in government health services, you say urban elite practitioners will be around for quite a while and can care for themselves in private practice. Although they are the main people who speak for indigenous medicine within the government bureaucracy, you recommend that no research be done on ways for them to participate more effectively in the state medical system. You deal only with the village practitioners. This recommendation to "set aside" the possible role of the urban practitioners of indigenous medicine corresponds to the attitude of the Bhore Committee Report of 1946. That Committee surveyed medical institutions throughout India. It was the first large-scale survey of health problems and medical services in India, and it was used by the government for 15 years to establish guidelines for developing the medical system. But the Committee pretended that the indigenous system did not exist. There was nothing in its report about the numerous colleges, hospitals, clinics and other institutions for indigenous medicine.

When you think about who to use to improve health services in India, you must not put the educated, urban practitioner of indigenous medicine aside. These are strategic people for the overall system.

Carl Taylor. Can we have clarification of whether you mean who to use in terms of service or in research. You are not thinking about just using them and their insights in research?

Charles Leslie. No, I am talking about service. The indigenous colleges of medicine, the professional associations, the Ayurvedic and Unani pharmaceutical companies are institutions of the urban, elite practitioners, and these are the people about which there has been a policy of no policy.

I am unsure about this, but it appears to me that China has had a more effective policy than India for developing medical services to the country as a whole. The Chinese policy has been to fully use the indigenous system to extend and improve the modern medical system, rather than to have a no policy position toward the educated, professionalized, indigenous practitioners.

Carl Taylor. Could we get some reactions to this.

Ralph Croizier. Of course the Chinese model is very relevant. The problem is that we do not really know what has gone on in China. The reservation I have regarding your comparison of China and India is that the medical policy in China does not exist in a vacuum. There has been a revolution, and the policy of integration exists in the context of strong state control, to put it mildly. A great deal of head knocking has gone on—most of the knocking on the head of the modern medical profession. Also, there are no pure traditional Chinese doctors like the Ayurvedic practitioners in India who say, in effect, we do not want to have anything to do with modern medicine. Those have been re-educated. Without a

similar political process in India, I am skeptical that the democratic, pluralistic system that prevails now could make this work at all. In fact, it might really be a reactionary step. Reasoning from the Chinese situation, where I believe the broad social and political context has been removed with which traditional medicine, particularly the elite practitioner was identified, I would guess this is not the case in India and that the elite practitioners might be politically and socially a conservative force.

Paul Unschuld. I see the situation quite differently from Leslie. At one time the Chinese freely incorporated traditional practitioners into the public health system, but I think this time is over, and that these attempts actually failed. Since that failure the Chinese have backed the barefoot doctor, and in this new system you do not read one word about the traditional practitioners, the ones they had backed before. I believe the Chinese have a policy not unlike the one that Dr. Taylor recommended. The Chinese conducted extensive research on drugs, and they found many with properties that are very efficacious. They use the medications by incorporating them into the practice of a newly developed and well publicized practitioner. The greatest advantage of this policy is the complete new model of doctor. Actually, we must judge by evaluating the propaganda, but apparently the Chinese now have what Leslie called a policy of no policy toward the old practitioners.

Charles Leslie. What I want to stress is that there is now in India a dual system of professionalized medicine, with a large infrastructure of institutions for Ayurvedic and Unani medicine that are in a very ambiguous paramedical relationship to the modern medical system. A medical catastrophe would occur if that infrastructure was suddenly abolished, because it serves to meet a very large part of the demand for medical care. I do not think Croizier is correct to infer that the so-called elite practitioners who created this infrastructure were or are now a "conservative force". They support various political leaders and parties—here is the Indian pluralism again—and they have certainly been modernizing indigenous medical education and practice. If modernization is "progressive", then they are progressive.

The medical system depends on the infrastructure of professionalized indigenous medicine, and yet the attitude of physicians trained in modern medicine prevents a rational approach to the utilization of the Ayurvedic colleges, hospitals and other institutions to improve the overall system of medical services.

The Chinese have been more direct and practical than the Indians in utilizing indigenous medical institutions. Yet the Indians have had more to work with, since the professionalization of indigenous medicine was more highly developed in India in 1949 than it was in China. For research oriented to practical affairs to turn away from the professional urban practitioners of traditional medicine, and to confine itself to the village midwife, or to promoting the gradual process by which other village practitioners will be replaced, is to turn away from a major health planning problem in India.

Frederick Dunn. I would like to support Leslie. I have been thinking about American medical education. We have a large number of medical schools, and there is a clear differentiation between a few schools that tend to concentrate on the education of educators and on the theoretical development of medicine, and a large number of schools that are concerned primarily with training practitioners. Something like this is what we are talking about with respect to Ayurveda. The elite, urban aspect is the educational, theorizing part of Ayurveda. Insofar as Ayurveda can be incorporated into the government medical system, it would be a beheaded system if the urban institutions were excluded. I do not mean to suggest that all of the system can be incorporated, because obviously research would be

directed to defining those parts of the elite area, as of the non-elite area, that could usefully be fitted into an integrated system of government services.

Finally, on the point of conservatism. While the elite practitioners may be a conservative force, as has been suggested, I would think that the non-elite would be at least as conservative.

Carl Taylor. The fact that they are both conservative does not make them more amenable. The fact that the whole body of practitioners is conservative just makes it that much more of a problem for a progressive reformer to incorporate them into his system.

One other comment. I agree with a lot of what you said, but I tried to separate research activity, where it is obviously desirable to develop a relationship with the elite of the Ayurvedic system, from what can be done to provide mass service. What are you recommending? You not only want the contribution of the learned urban practitioner of Ayurvedic medicine at the intellectual planning level, where he is already making a contribution, but you want research on how to incorporate him into the health services. That is what you guys are recommending?

Charles Leslie. That is exactly what we are talking about. A lot of practitioners, with their associations and colleges, are in official and quasi-official relationships already. They get government funds. There are government colleges, hospitals, and pharmaceutical plants that manufacture indigenous medicine, and government dispensaries where they are prescribed. The question is whether you could increase the efficacy of the overall delivery of health services by a fuller recognition of the contribution Ayurvedic and Unani institutions make to health care in India.

Carl Taylor. I think we have a very clear issue posed here.

Marjorie Topley. In China, is the barefoot doctor someone who was the traditional village specialist, and who is now being brought back in a specialized role? One observation I would like to make is that Chinese medicine seems to have a new theory, which is the thought of Mao. This is the little book which barefoot doctors carry as a reference for what they do.

Paul Unschuld. I would say that it is a great advantage that the barefoot doctor is clearly distinguished from the old traditional practitioners. They are young people out of the middle and lower peasant class, if I use the right Maoist term, who are trained in the basic skills for western style diagnoses and are given authority to treat minor diseases by means of effective indigenous medicine, as well as by simple chemotherapy. But they must bring serious diseases to more fully trained doctors.

They receive 3-6 week courses in centers, and at one time were trained by students of medical schools who were forced to go into the countryside. The research work on the traditional drugs has been in pharmacological research laboratories, and has not come out of old texts. The ingredients have been proven scientifically to be useful, and the ability to use them in modern medical terms is important.

Marjorie Topley. In that case, what is the relationship between the local system and these centers that exist somewhere else? I gather that the barefoot doctors are encouraged to use locally popular remedies, so if they do not get their training in the local areas, who tells them about these herbs?

Paul Unschuld. First, they are supplied with effective traditional drugs by the government. Second, we read many stories that the barefoot doctors after a short training program go into the mountains close to their villages to search for drugs which they test. Also, they are said to seek the advice of older people in the locality. The most important thing about their practice is that they are not trained to think in the old terms of Chinese medical theory.

Marjorie Topley. But they rely on older people in the area.

Paul Unschuld. The tradition is cut off. That is the main point.

Manfred Porkert. By what authority can you say that?

Paul Unschuld. Of course, we can only interpret the stories they publish about barefoot doctors.

Manfred Porkert. Well, they do not say that directly. We have no direct information on this.

Marjorie Topley. There are people in Hong Kong who were formerly barefoot doctors but who have come out of China. They now work as male nurses in some of the big hospitals. My impression from talking to people about this is that there has not been as great a break with the traditional system as Unschuld thinks. The barefoot doctors have to ask the local people about their practices, and to learn from them. Even if they are trained outside the community, when they come to the local situation they have to respond to what the people believe and want.

Paul Unschuld. Perhaps the ideas and policy which I described do not work everywhere in China in the way they were intended to work. However, in Taiwan, where I have studied, many practitioners refer to the theoretical tradition of Chinese medicine, but they do not understand its terms, and they could shift quickly to another terminology. I think the same thing must also have been true in China. Quite a lot of these barefoot doctors will have a stock of empirical practices that were formerly related to Chinese medical theories, but they will not understand those theories, or try to rationalize their practices in terms of them.

Charles Leslie. Still, we have a point of information. What has happened since the Cultural Revolution to the professionalized practitioners of Chinese medicine who were learned people? And, before the Cultural Revolution, who trained the modern doctors who took courses in traditional medicine?

Ralph Croizier. The learned practitioners, by and large, were the people who gave courses on Chinese medicine to the modern doctors. But we do not know since the Cultural Revolution, or I do not know anyway, what has happened to them. They no longer receive the publicity that they used to have. This could be interpreted several ways. You could interpret it as Unschuld has done, and say that they have had their day and that they are being allowed quietly to fade away. Or you could interpret it another way. By and large, modern medical specialists have also dropped from the publicity, but they are still there. They are just not given publicity in the campaign for the rural cooperative health system in the way the barefoot doctors are publicized. That is what the drum beating is about. But what the drum beating is about is not necessarily the whole medical picture. We will have to get to China. In the meantime someone should be interviewing systematically those barefoot doctors who have come to Hong Kong.

Manfred Porkert. I want to make a point in connection with what William Caudill said a while ago. My point refers only to China and Japan. I do not make any inference for India. The Japanese government, and much less of course, the Chinese government, is not going to ask our advice on how they should improve, and can improve, health care. The only way that we can have the minutest influence of this kind is by our theoretical work to furnish paradigms which they cannot furnish because they do not have the perspective on medical systems generally, and on the Chinese system or the Japanese system in particular, which we bring to the subject. The Chinese or Japanese may of their own accord come to use ideas which we also use in our studies. But if we say to them that their medical systems have such-and-such weak points, they will be reluctant to accept our ideas. Nobody, and above all the Chinese, likes to be criticized by the westerner.

Carl Taylor. What you say suggests that wherever we work will differ from other countries.

William Caudill. I do not think that each system is unique. This is a conference on comparative Asian medical systems, but we have not confined ourselves solely to that. Renée Fox, Mark Field and others presented material on Western medicine, or on other more general topics. Although your work takes place in India, you refer what you do to more general contexts.

We have been talking about India, Japan and China, but there are many parallels in the United States. In a way, we have something like Ayurvedic medicine in the United States. We have chiropractors, osteopaths, spirit healers and so on. We have a host of people that perform medical roles. Whether they belong or do not belong to the formal medical system is a matter of one's faith and definition, but they behave in the area which is usually thought to be medical. And if we want to conduct research that will be useful for designing a better health referral system for community medicine, making it wider than in the past, we run into exactly the same problems we encounter in India. Are we going to bring the osteopath and chiropractor in, or the faith healers, or the man who by government contract dispenses methadone in Washington, D.C.? He is not a physician, but he is running a clinic where every day he puts heroin addicts on methadone. Is he part of the medical system? By my definition he is. If we are thinking about the better delivery of health services to wider proportions of the population, then a very exciting new definition of medicine is implicit in the issues we have discussed. India, China and Japan happen to be our focus here, but the definition is relevant to the United States and other countries.

Carl Taylor. In learning how to organize community health services the United States has been indebted to developing countries. This has been less true for the mental health centers, I think, than for other health center activities. The experimental programs that really set the pattern for the whole neighborhood health center movement in the United States were developed by persons who had learned the business overseas.

Alan Beals. The more I have listened, the more I have felt that there is an incredible government bias in this discussion. We seem to believe that a system developed by a government and imposed upon the people *necessarily* has some influence. I have studied culture change for years, and I hardly ever consider government policy in thinking about what happened.

When some people refer to the medical system in India, they mean the doctors that are on the government payroll, but I mean everybody that is treating a patient. If someone wants to do research that may have practical utility for improving the medical system, but says we should consider only one set of practitioners and set the other practitioners aside, particularly the Ayurvedic ones, what can then be done about the mercurial drugs that they use in treating patients? Should research look for replacements for these drugs that can be advertised through the existing pharmaceutical channels? Or should research be directed to the ways these practitioners could be given better instructions on how to use penicillin? Should studies help them to improve their diagnostic skills and way of referring patients to modern scientific medicine, because everyone seems to agree that they do refer to modern medical institutions? This is a health education problem. Whether or not they are included in some official medical scheme, the fact is that they are there, and they are there in large numbers. If you do not do anything about them, then all those patients who do not go to the Western medical practitioner receive worse care than they would if the government took notice of what was going on.

Carl Taylor. I can see that my comment that we should start by looking at the urban

practitioners of traditional medicine and then put them aside and concentrate on village practitioners has drawn considerable fire. I think it has been important in posing the issue. Those who are involved in health planning have to consider the overall medical system from the perspective of what governments can manipulate.

I would like to reiterate that our research can contribute a lot of practical things to health planning. Although we have spent most of the time talking about the "how" and the "who" questions posed by my opening remarks, we must balance our interest in these questions by recognizing that the thing that will be most useful to health planners is our ability to identify the "what" issues, the content of traditional Asian medicine that can be utilized in state medical systems. On the basis of better identification of these components they may work out relationships with traditional practitioners on a practical basis. I hope that we will have sustained interactions with continuing feedback between administrators in the health services of Asian countries and the academic community we represent.

REFERENCES

1. Wenner-Gren Foundation for Anthropological Research, Burg-Wartenstein Symposium No. 53, July 19-27, 1971, Charles Leslie, organizer. Participants in the symposium who appear in the edited transcript of the session here published are, in alphabetical order: ALAN R. BEALS (University of California, Riverside), WILLIAM CAUDILL (National Institute of Mental Health), RALPH C. CROIZIER (University of Rochester), FREDERICK L. DUNN (University of California, Berkeley), CHARLES LESLIE (New York University), MANFRED PORKERT (University of Munich), CARL E. TAYLOR (Johns Hopkins University), MARJORIE TOPLEY (Hong Kong), PAUL U. UNSCHULD (Munich). Other participants were: A. L. BASHAM (Australian National University), J. CHRISTOPH BURGEL (University of Bern), MARK G. FIELD (Boston University), RENEE C. FOX (University of Pennsylvania), BRAHMANANDA GUPTA (Shyamadas Vaidya Sastra Pith), MERVYN A. JASPAN (University of Hull), W. T. JONES (California Institute of Technology), EDWARD MONTGOMERY (Washington University), GANANATH OBEYESEKERE (University of California at San Diego), LITA OSMUNDSEN (Director of Research for the Wenner-Gren Foundation), YASUO OTSUKA (Yokohama City University Medical School), IVAN POLUNIN (University of Singapore). In addition, RAYMOND and ROSEMARY FIRTH attended and contributed to several sessions of the symposium. ZELDA LESLIE was rapporteuse and transcribed the session here published.
2. The symposium discussed conceptual models and priorities for further research. A report of this session of the symposium, "Research Needs to Develop the Comparative Study of Asian Medical Systems" has been prepared by Charles Leslie and will be published in *Asian Studies Professional Review*, a new publication of the Association for Asian Studies. The theoretical issues discussed in this report are: (1) the biases introduced in comparative research by using the terms "Western", "scientific" and "modern" to refer to one system, in contrast to "traditional", "folk", or "primitive"; and (2) the utility of different conceptual models of "the medical system" for comparative studies.